MDR Tracking Number: M5-04-0384-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 09-10-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic procedures, myofascial release, electrical stimulation and ultrasound on 10-04-02 through 10-11-02 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 10-04-02 through 10-11-02 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 17th day of December 2003.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION - AMENDED

Date: December 16, 2003

RE: MDR Tracking #: M5-04-0384-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer that has ADL certification.

The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

According to the supplied documentation, it appears that the claimant injured her neck, right shoulder, right arm and right wrist when she fell at work. The claimant has undergone chiropractic care, physical therapy and has had 2 surgeries performed as part of her treatment. The claimant received her therapy at ___ and her surgical intervention was performed by ___. The documentation supplied primarily focused on the timeframe around the services in dispute. It appears that the claimant underwent 27-treatment sessions post-surgery from 07/19/2002 – 10/11/2002. A FCE was performed on 10/07/2002, which revealed the claimant was able to work light duty, but had some abnormal findings with her pain perception. The notes for the dates in question were reviewed. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including office visits, therapeutic procedures, myofascial release, electrical stimulation, and ultrasound rendered between 10/04/2002 through 10/11/2002.

Decision

I agree with the insurance company that the services rendered between 10/04/2002 – 10/11/2002 were not medically necessary.

Rationale/Basis for Decision

The documentation reports that the claimant was seen from 07/19/2002 – 10/11/2003 for therapy to her right wrist. The claimant improved while undergoing passive and active therapy at___. After an initial 6-8 week regimen of therapy, it would be necessary to perform objective examinations to determine the claimant's progress. This test was done by ___ on 10/07/2002. ___ determined that the claimant was at a light duty capacity. This capacity would be sufficient enough for the claimant to return to her normal duties. The claimant also tested positive for several tests that suggest the claimant was not providing maximum effort. After the initial 6-8 weeks of therapy and enough improvement of symptoms to return to her normal duties, it would be necessary for the claimant to continue her therapy at home. Continuing to treat beyond 09/13/2003 is not considered reasonable or medically necessary. Continued treatment could possibly induce doctor-dependence and further inhibit the claimant from returning to her pre-injury state.